



WHEN THE GOVERNMENT ALLEGES HEALTH CARE ORGANIZATION FRAUD, IS THERE COVERAGE?

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It's no secret that during the last several years, the U.S. government has invested substantial resources in detecting, investigating and prosecuting health care fraud and abuse. No health care organization (HCO) is immune from this scrutiny.

As more fully set forth in Table A below, health care organizations have incurred millions of dollars in defending and resolving allegations of health care billing fraud and abuse, and the trend will no doubt continue. In an effort to highlight the types of exposure presented by an HCO when the government comes knocking at its door, we provide the following hypothetical scenario.

KNOCK, KNOCK: THE HYPOTHETICAL FALSE CLAIM ACT INVESTIGATION AND ACTION – ARE YOU READY?

Since 1996, ABC Health System (ABC), a privately held health care organization, has been delivering affordable, quality care to those who depend on government assistance. ABC's approach to care is viewed favorably by disparate groups, including community members and security holders. In late 2009, federal and state

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authorities began investigating claims submitted by ABC in connection with certain New York provider contract services to ABC at the New York City provider sites. That investigation focused on the providers' billings for services they did not render.

In the third quarter of 2010, the FBI appeared on the door step of ABC's New York flagship facility with search warrants, demanding information on all transactions between ABC and several controlled provider groups. The FBI's investigation of ABC was prompted by a tip from an ABC Accounts Payable "whistleblower" employee, claiming that ABC was fraudulently submitting inflated provider reimbursement requests and that ABC executives were aware of the billing scheme. The Department of Justice (DOJ) joined the whistleblower's False Claims Act (FCA) action filed under seal against ABC; the State of New York brought a parallel state-based false claim action.

IS YOUR HEALTH CARE ORGANIZATION COVERED FOR REGULATORY ACTIONS?

With the media attention surrounding the DOJ action, your CEO is focused on damage control and is probably not thinking about the insurance implications of defending and settling these actions. The urge to hire counsel trusted by the CEO – with price being no object – is strong. However, as the risk manager, you know that insurance policies are corporate assets that have cooperation provisions, requiring insurer consent to both retention of counsel and counsel's fee schedule – up front. Of course, if there is no insurance that will respond to the action, the cooperation provisions become moot. However, ABC needs to evaluate whether some coverage may be afforded by its Health Care Directors' & Officers' (D&O) or Health Care Professional Liability (HPL) policies. Hence, coverage considerations must remain primary from the moment your organization becomes the target of an FCA investigation or action.

GIVE ME COVER

The damage components of a False Claim violation listed at 31 U.S.C. § 3729(a) for which an HCO might seek coverage include: (1) recoupment of overpayments; (2) fines and penalties; (3) trebled damages inclusive of the whistleblower's share, if any; and (4) awarded attorney fees.

Here's the decision tree that guides us:

1. Do the FCA allegations satisfy the insuring agreement of either your Directors' & Officers' (D&O) or Health Care Professional Liability (HPL) policies? For the purposes of this discussion, we will focus on the D&O coverage available to private and non-profit health care organizations.
2. Has the health care organization satisfied the necessary conditions of the policy (e.g., paid premium, timely reporting, cooperation with carrier)?
3. Is there a regulatory exclusion?
4. Are there other exclusions that restrict or eliminate coverage?
5. Are there insurance or financial products beyond the HCO D&O policy to consider?

1. DO THE ALLEGATIONS OF VIOLATION OF THE FALSE CLAIM ACT SATISFY THE INSURING AGREEMENT OF EITHER THE D&O OR HPL POLICY?

The insuring agreement is the insurer's "Promise to Pay." At first glance, the D&O and D&O HPL policies' insuring agreements look similar:

- HPL: The Insurer will pay...**Loss**...as a result of a **Claim**... arising from a **Wrongful Act** in the *rendering of or failure to render **Medical Services*** by or on behalf of the Insured... (italics supplied)
- D&O: Most policies contain the following three main insuring agreements:
 - **Side-A Insuring Clause:** The **Insurer** will pay **Loss** of the **Insured Persons** for which the Insured Persons are not indemnified by the **Organization** and which the **Insured Persons** have become legally obligated to pay by reason of a **Claim** first made against **Insured Persons** during the Policy Period.

- **Side-B Insuring Clause:** The **Insurer** will pay the **Loss** of the **Organization** for which the **Organization** has indemnified the **Insured Persons** and Which the **Insured Persons** have become legally obligated to pay by reason of a **Claim** first made against the **Insured Persons** during the **Policy Period**.
- **Side-C Insuring Clause:** The **Insurer** will pay the **Loss** of the **Organization** for which the **Organization** has become legally obligated to pay by reason of a **Claim** first made against the **Organization** during the **Policy Period**.
 - In addition, many policies provide coverage for directors and officers of the **Insured Organization** who serve on the board of an outside not-for-profit organization, excess of such outside non-profit organization's insurance and indemnity.
 - With respect to federal false claims, anti-kickback claims, self-referral claims or similar allegations of fraud or abuse, **most D&O policies will either exclude these claims in their entirety, or provide separate coverage sublimit by endorsement under a separate insuring agreement.**

Which policy does one look to for coverage? The difference is the capacity in which the insured is acting. In our introductory scenario, ABC is not "rendering Medical Services" when submitting its providers' claims to the government, while allegedly knowing that the claims were false. **Thus, no HPL coverage applies.**

However, since ABC is managing billing services for, or on behalf of, its own providers, it may fall within the scope of one or more insuring agreements under the D&O policy. It is also essential to analyze to what extent the defense costs, fines and penalties, attorney fees and amounts constituting "overpayments" fall within the scope of coverage. Finally, consideration should be given to the likelihood of a subsequent claim alleging that the executives failed to manage or supervise Medicare or Medicaid reimbursements. The specifics of the D&O policy's terms and conditions will determine whether the policy may be triggered several times, or not at all.

Two more defined terms in the D&O insuring agreement need to be satisfied before moving on: do our facts describe a **Claim**? And is there **Loss**?

- **Claim** – The HCO D&O policy will typically include "a written demand against any **Insured** for monetary damages or non-monetary or injunctive relief," civil proceedings and criminal proceedings in the definition of **Claim**. In certain cases, the receipt of a subpoena, search warrant or investigative order does not trigger the definition of **Claim** (more about defense expense coverage of subpoenas that are not deemed Claims later), but once the Department of Justice joins the FCA action against ABC, and NY files a parallel state-based false claim action, the definition of **Claim** will likely be satisfied on a D&O policy, assuming there is not an exclusion for Claims pertaining to the Federal False Claims Act or similar laws. Only select D&O policies will offer coverage for informal regulatory inquiries of an **Insured Person** (e.g., a request to appear at a meeting, deposition or interview or produce documents).
- **Loss** – This boils down to analyzing coverage for damages, judgments, settlements, **Defense Costs** and fines and penalties, but piecing together how we find coverage for each component of Loss involved in an FCA action is akin to finding the prize in a treasure hunt.
 - If we put policy exclusions to one side, **Defense Costs** are typically a component of **Loss** and owed to ABC, even if the **Defense Costs** are attributable to damages not included in the definition of **Loss**. This is because most competitive D&O policies will have express language clarifying their intent to provide coverage for **Defense Costs** coverage for items specifically excluded from **Loss**, which is favorable to ABC. However, a regulatory exclusion could take away this obligation to pay **Defense Costs**. As stated earlier, most commercial health care D&O policies will provide **Defense Costs**

coverage for regulatory actions under a sublimit on an endorsement with a separate insuring agreement for regulatory claims, but this coverage is a quarter of a loaf at best. Full limits coverage for Defense Costs is critically important when an insured is battling the deep pockets of state or federal enforcement agencies.

- **Damages:** Observations with respect to the potential match-up of the standard HCO D&O carrier policy form and the FCA damage components of ABC's potential settlement are set forth in [Section 4](#) and in our Table B below.

2. HAS THE INSURED SATISFIED THE NECESSARY NOTICE AND COOPERATION CONDITIONS OF THE HCO D&O POLICY?

In order to tap the insurance asset for at least defense costs incurred on a government claim, it is imperative that the HCO timely report these claims to be compliant with each policy's notice provision. It is also critical to secure the consent of your HCO carrier with respect to the identity and hourly rate of defense counsel that you wish to retain so as to start the legal meter running on the insurer's dime.

3. DOES THE HCO D&O POLICY'S REGULATORY EXCLUSION BAR COVERAGE?

Some HCO D&O policies contain no government entity action exclusion; others do, with affirmative coverage carve-backs for: 1) defense costs even if no indemnity is covered; 2) indemnity for specific government actions, such as EMTALA or HIPAA. Note that not all HCO D&O forms grant the same scope of regulatory coverage and this is an important term to be negotiated. As alluded to earlier, most D&O policies will either exclude these claims in their entirety or provide separate coverage sublimit by endorsement under a separate insuring agreement.

This separate insuring agreement will likely offer **Defense Costs** coverage; in some cases it will offer coverage for at least a portion of FCA damages, judgments and settlements, and in rare cases will include coverage for civil fines and penalties.

4. DOES THE CONDUCT EXCLUSION OR OTHER POLICY TERMS (I.E., LOSS DEFINITION) RESTRICT OR ELIMINATE COVERAGE FOR AN FCA ACTION?

Here, consider the "conduct" exclusion. This is another high-impact policy term that warrants stiff renewal negotiations so that the insurer will have the burden to demonstrate that the HCO and/or its management *deliberately committed* criminal or fraudulent acts, or obtained a profit or advantage to which they were not legally entitled. Since almost all D&O **Claims** will include an allegation of fraud or similar conduct, it is imperative to limit the carrier's ability to deny coverage for **Defense Costs** at a premature stage. The most favorable policy language will state that the conduct exclusion will not be triggered until a "final, non-appealable adjudication in the underlying action." Importantly, this language limits the carrier's ability to commence a separate declaratory proceeding (separate from the underlying litigation) after which it can use an adjudication of wrongful conduct in a separate action as an argument to deny coverage. Since the penalties that the government may assess against a health care entity in an FCA action are severe – exclusion from government programs and commensurate loss of revenue – the target HCOs often settle rather than go to trial. Significantly, the HCO civil settlement agreements with the OIG do

not contain an express admission of fault or liability. The OIG is more concerned with repayment, the corrective action plan, recovery of fines and penalties, treble damages (inclusive of the whistleblowers' share) and attorneys' fees. Ultimately, the ability of the **Insurer** to deny coverage may be contingent on the specific wording of the conduct exclusion.

Even if the HCO insurer does not meet its burden with respect to enforcing the conduct exclusion, one must examine the HCO D&O policy's loss definition to obtain insight on the extent of coverage for any damages/indemnity that the HCO must pay. Many standard HCO D&O forms exclude coverage for civil and criminal fines and penalties and the restitution or repayment of overpayments. Most policies will provide some form of coverage for punitive, exemplary and multiplied damages if insurable under law and for the portion of damages constituting attorneys' fees.

Defense Costs incurred by an HCO in responding to a government subpoena require separate comment. Typically, pre-claim expenses are not covered by an HCO Policy. Rarely will D&O policies offer coverage for informal regulatory inquiries of an **Insured Person** (e.g., a request to appear at a meeting, deposition or interview or to produce documents). Importantly, depending on the specifics of the definition of **Claim**, coverage for **Defense Costs** (including discovery expenses) may not be triggered until a formal proceeding has begun. While the insurer has an interest in the manner and quality of the HCO's response to the subpoena because it wishes to avert assertion of a formal claim/suit against the HCO, it is hesitant to cover expensive investigations wherein the government is often engaged in a fishing expedition and casts a broad net to obtain support for some type of claim. In certain cases, there can be a fine line between the insurer's intent to cover formal, targeted investigations and not cover informal investigations and other "routine" inquiries or audits.

5. ARE THERE INSURANCE OR FINANCIAL PRODUCTS BEYOND THE HCO D&O POLICY TO CONSIDER FOR COVERAGE OF AN FCA CLAIM?

Carriers are beginning to assess their appetites for HCO FCA exposure. Ironshore has rolled out a standby capital approach wherein an HCO can purchase an option to purchase a government billing errors and omissions coverage grant which would provide \$5M in coverage for essentially all aspects of an FCA suit, including fines, penalties, restitution, attorneys' fees, etc. NAS and Beazley each provide a government billing E&O product for providers that includes defense costs coverage and civil fines or penalties, but does not extend coverage to criminal fines or penalties, treble damages, etc. In Table B below, we set forth the various components of a False Claim Act action and then compare how the standard HCO D&O, Ironshore, Beazley and NAS forms would respond.

For now, the way forward is to evaluate, case by case, our client's interest in explicit negotiations with its HCO D&O carrier (which for now may be its own captive or RRG). Willis is working hard with the HCO market's D&O underwriters to develop a product with affordable and meaningful False Claims Act protection – a game-changing coverage in a hardening market.

TABLE A

NOT-FOR-PROFIT HCO SETTLEMENTS

HCO	DATE	SUMMARY OF ALLEGATIONS	SETTLEMENT AMOUNT	LINK
Healthways	03/13/2009	FCA lawsuit filed 15 years ago by A. Scott Pogue, a former employee of Diabetes Treatment Center of America. The lawsuit alleged Diabetes Treatment Centers illegally paid doctors for referrals. The U.S. Government did not join the suit, but will collect more than \$28 million.	\$40M	Medical News Today
Detroit Medical Center	12/30/2010	Violated the False Claims Act, the Anti-Kickback Statute and the Stark Statute, by engaging in improper financial relationships with referring physicians.	\$30M	Lansing, Michigan - The Legal Examiner
SouthernCare Hospice	01/15/2009	An Alabama-based hospice company has agreed to pay \$24.7 million to settle charges it billed Medicare for ineligible patients. The company operates 99 locations in 15 states.	\$24.7M	U.S. Dept. of Justice
Dr. Walter Janke, Lalita Janke, and Medical Resources LLC	11/24/2010	Caused Medicare to pay inflated amounts based upon the submission of false diagnosis codes.	\$22.6M	U.S. Dept. of Justice - Office of Public Affairs
St. Joseph Medical Center	11/09/2010	Violated the False Claims Act, the Anti-Kickback Act, and the Stark Law when it entered into a series of professional services contracts with MidAtlantic Cardiovascular Associates (MACVA).	\$22M	U.S. Dept. of Justice - Office of Public Affairs
St. Jude Medical Inc.	01/20/2011	Intentionally used post-market studies and a patient registry as means to pay kickbacks to induce participating physicians to implant St. Jude pacemakers and implantable cardioverter defibrillators (ICDs) in their patients.	\$16M	U.S. Dept. of Justice - Office of Public Affairs

TABLE A

NOT-FOR-PROFIT HCO SETTLEMENTS *(continued)*

HCO	DATE	SUMMARY OF ALLEGATIONS	SETTLEMENT AMOUNT	LINK
John D. Archbold Memorial Hospital Inc.	12/22/2010	Thomasville Hospital made false representations to the Georgia Department of Community Health Medicaid Program.	\$13.9M	U.S. Dept. of Justice - Office of Public Affairs
Catholic Healthcare West	2/18/2011	Seven of CHW's hospitals in CA and AZ submitted false claims to Medicare related to overbilling.	\$9.1M	Fierce Healthcare
Simi Valley Hospital	11/3/2010	Knowingly submitted false claims to Medicare for chemical dependency and psychiatric patient services performed between 1991 and 1997.	\$5.15M	Dept. of Justice - Central District of CA - 11/3/2010
Christus Spohn Health System	6/21/2012	Improperly admitted outpatients as inpatients to send false billings to Medicare.	\$5M	U.S. Attorneys Office - District of Texas
Dr. Mark W. Izard	6/01/2011	Fraudulently billed Medicare and Medicaid for medical services that he did not provide.	\$2.2M	Hartford Courant
St. John's Mercy Health Care and St. John's Health System, Inc.	12/30/2010	Foot Clinics at St. John's Hospital improperly overbilled Medicare.	\$2.2M	Becker's ASC Review
Dartmouth-Hitchcock Medical Center	4/26/2011	Improperly billed various federal health programs for services performed by resident staff exclusive of sufficient supervision by physicians	\$2.2M	Beckers Hospital Review
Marci Taylor, Treehouse Behavioral Services, PLLC, Treehouse Pediatric Center, PLLC, and The Autism Clinic of Texas	09/21/2011	Submitted false claims for payment to the TRICARE program for applied behavior analysis (ABA) for services that were not provided by certified therapists.	\$1.4M	San Antonio Business Journal
Christus Health Systems	10/6/2010	Several hospitals in Texas and Louisiana fraudulently billed Medicare for ineligible costs and expenses and failed to disclose overpayments.	\$970,987	The SantaFe New Mexican
St. Francis Hospital and Medical Center	8/10/2011	Overbilled Medicare for a prostate cancer treatment.	\$516,527	U.S. Attorneys Office - District of Connecticut

TABLE B
COMPONENTS OF A FALSE CLAIM SETTLEMENT AND INSURABILITY

	STANDARD HCO D&O FORM	IRONSHORE GOVERNMENT BILLING E&O	BEAZLEY PROVIDER GOVERNMENT BILLING E&O	NAS GOVERNMENT BILLING E&O
Who is Policy Purchaser?	Provider	Provider	Provider	Provider
Risk Financing Approach	Risk Transfer	Standby Capital	Risk Transfer	Risk Transfer
Defense Costs	MAYBE	Up to max agg of \$5M	YES	YES
Subpoena/ Investigation Defense Expenses	MAYBE	Up to max agg of \$5M	YES	NO
Civil Fines & Penalties	MAYBE	Up to max agg of \$5M	YES	YES
Criminal Fines & Penalties	NO	NO	NO	NO
Repayment of Overpayment	NO	Up to max agg of \$5M	NO	NO
Treble Damages (3x Repayment Amount)	MAYBE	Up to max agg of \$5M	Part of Civil Fines	NO
Whistleblower Share	MAYBE	Up to max agg of \$5M	Part of trebled damages	NO
Awarded Attorney Fees	MAYBE	Up to max agg of \$5M	SILENT	NO
Conduct Exclusion Voids Coverage	Most competitive language: "Final, non-appealable adjudication in the underlying action"	Final adjudication/ admission of liability generally does not occur/ trigger exclusion	Carves back federal and state FCA violations	Collateral Proceeding can trigger conduct exclusion
Evidence of Intent of U/W to Cover FCA	Depends on specifics of regulatory coverage endorsements and policy exclusions	YES	YES	YES

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